REQUEST FOR CERTIFICATION TO TREAT GLAUCOMA PURSUANT TO NRS 636.2895

STATE OF _____)
) ss.
COUNTY OF _____)

I, _____, of lawful age and under penalty of perjury certify as follows:

1. I am duly licensed optometrist practicing in the State of Nevada, at _____ under License Number _____;

2. I have taken and passed the National Board of Examiners in Optometry examination for the Treatment and Management of Ocular Disease on or after January 1st, 1993;

3. I have received a certificate from the Nevada State Board of Optometry certifying me to administer and prescribe therapeutic pharmaceutical agents;

4. I have, in consultation with an ophthalmologist licensed in the State of Nevada, treated a total of fifteen [15] patients for a period totaling at least twelve [12] months.

5. I provided copies of the medical records for each patient to the co-managing ophthalmologist, together with a course of treatment for each patient;

6. The co-managing ophthalmologist diagnosed the patients listed herein with glaucoma;

7. I was notified by the co-managing ophthalmologist that he/she agreed with the course of treatment outlined by me;

8. I conducted such necessary optometric examinations of the patients as were

deemed prudent by me and the consulting ophthalmologist, during the course of the patients' treatment; and

9. I acknowledge the records for each of the fifteen [15] patients treated, must be retained by me for a period of not less than five [5] years, and that the records are subject to examination by the Nevada State Board of Optometry.

Dated this _____ day of _____, 20_____.

_____

Subscribed and sworn to before me this
_____ day of _____20____.

_____
NOTARY PUBLIC [SEAL]

1. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

2. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

3. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

4. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

5. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

6. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

7. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

8. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

9. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

10. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

11. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

12. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

13. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

14. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

15. Patient Name:

Address:

Date treatment commenced:

Synopsis of Treatment Plan:

VERIFICATION OF CO-MANAGING OPHTHALMOLOGIST

STATE OF NEVADA)
) ss.
COUNTY OF_____)

Under penalty of perjury, _____the undersigned declares that:

1. He/she is a duly licensed and practicing ophthalmologist in the State of Nevada;

2. He/she diagnosed the patients listed herein with glaucoma;

3. He/she co-managed the treatment of the patients listed herein for a period of not less than one [1] year, commencing on or after October 1st, 1999, with _____ _____, O.D.

Dated this _____ day of _____, 20_____.

_____

Subscribed and sworn to before me this
_____ day of _____,20____.

_____
NOTARY PUBLIC [SEAL]